Nova Scotia
Advisory Council on
The Status of Women

Conseil consultatif sur la
condition féminine de la
Nouvelle-Écosse

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The Journey Continues ...

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Women and Healthcare:

A Brief to the Commission on the Future of Health Care in Canada

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Nova Scotia Advisory Council on the Status of Women

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Advancing equality, fairness & dignity for all women in Nova Scotia

The **Nova Scotia Advisory Council on the Status of Women** was established by provincial statute in 1977. The Council's mandate under the *Advisory Council on the Status of Women Act* is to advise the Minister Responsible for the Status of Women and to bring forward the concerns of women in Nova Scotia.

The Council's work touches on all areas of women's lives, including:

- family life
- economic security
- legal rights
- sexuality
- health
- education
- paid & unpaid work
- violence

Council works toward the inclusion of women who face barriers to full equality because of race, age, language, class, ethnicity, religion, disability, sexual orientation, or various forms of family status.

We are committed to voicing women's concerns to government and the community through policy research, information services, and community outreach.

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Women and Healthcare: A Brief to the Commission on the Future of Health Care in Canada

I Introduction

The Nova Scotia Advisory Council on the Status of Women is pleased to present a brief to the Commission on the Future of Health Care in Canada. The legislated mandate of the Council is to bring forward to government issues of interest and concern to women and to advise government on matters relating to the status of women. Since it was formed in 1977 the Council has worked on a wide range of issues with all levels of government, women's groups, and other organizations serving women, making in total over 1,000 policy recommendations.

This brief is based on women's health research, on issues related to healthcare reform, Council's long experience in addressing women's issues, and on input from Council members and other women's organizations. It provides a "big picture" approach to the issues being addressed by the Commission from the perspective of what we believe to be the major concerns of women.

Why women are concerned about healthcare

Women are particularly concerned about the future of healthcare. Not only do women have particular concerns related to their own health, but we also have a specific relationship to healthcare because of the unpaid caregiving work women do in families and the voluntary sector and the paid caregiving work women perform within the healthcare system itself. Women know that without a strong publicly supported healthcare system, their own healthcare is likely to be negatively affected.

In the past 20 to 30 years, women have identified a number of health issues and concerns which were historically ignored or neglected and which in many cases are only now being addressed through research and treatment. For example, it was long assumed that women are not as vulnerable as men to heart disease because most research was conducted with male subjects. But recent research which included women found them to be equally, if not more, vulnerable to heart disease. Understanding the biological processes involved in menopause and relief for those experiencing symptoms of discomfort have only recently been a subject of research and treatment. Breast cancer and osteoporosis—diseases which affect large numbers of women—were also neglected as areas for serious medical research until relatively recently.

Women also have significantly higher rates of chronic illness, longer-term activity limitations, and suffer more from depression than men.[1] Significantly more women than men in Canada, but especially in Nova Scotia, also suffer from high blood pressure.[2] In addition, women on average live longer than men and therefore have a number of health-related concerns and needs related to aging and old age. For example, women are more likely to be affected by arthritis and rheumatism than men[3]. Although women's life expectancy is almost six years greater than men's, only four of those additional years will be spent disability-free.[4]

As caregivers, women also have special concerns both about access to health care and the quality of care provided to loved ones, and about resources and support for caregivers—whether working as paid health care workers within the healthcare system or as unpaid family caregivers and volunteers.[5]

In addition to the specific health issues that affect women and the particular responsibilities women have for the care of others, women are more likely than men to live on low incomes. According to a recent statistical report by the Maritime Centre of Excellence for Women's Health, nearly one in five women in Atlantic Canada lives on low income. In Nova Scotia, the female low-income rate is 36% higher than the male rate—the widest gap in the country.[6] Particularly vulnerable are single mothers, women with disabilities, African Nova Scotian and First Nations women, and older women who live alone.

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1 Ronald Colman, GPI Atlantic, *Women's Health in Atlantic Canada: A Statistical Portrait*, Maritime Centre of Excellence for Women's Health, 2000, p.22.

2 In 1998/99 in Nova Scotia, 20.9% of women and 12.6% of men suffered from high blood pressure. Statistics Canada, *Health Indicators*, December 2001, Cat# 82-221-XIE.

3 In 1998/99 in Nova Scotia, 26.3% of women and 14.8% of men suffered from arthritis or rheumatism. As the population ages, the proportion of men and women suffering from this disease has grown. Statistics Canada, *Health Indicators*, December 2001, Cat# 82-221-XIE.

4 In 1996 in Nova Scotia, men aged 65-69 could expect to live an additional 16 years with 12.7 years dependence-free. Women aged 65-69 could expect to live an additional 20 years with 13.5 years dependence-free. Statistics Canada, *Health Indicators*, December 2001, Cat# 82-221-XIE.

5 In 1995 in Nova Scotia, 7% of women and 4% of men provided between 30 and 59 hours of unpaid care to children and 5% of women and 3% of men provided between 5 and 9 hours of unpaid care to seniors. Statistics Canada, *Census Data*, 1996.

6 Low income is defined as income below the Statistics Canada low income cut-off line. See Ronald Colman, GPI Atlantic, *Women's Health in Atlantic Canada: A Statistical Portrait*, MCEWH, 2000, p.18.

Gender, inequality, low income, and health status

The gender income gap and the higher rate of poverty amongst women are important because research has shown that income is related to health status.[7] Indeed, income, gender and culture have each been identified as important social determinants of health by Health Canada. It should come as no surprise, therefore, that women who live on very low incomes (such as single mothers and aboriginal women) are particularly susceptible to ill health.[8]

For immigrant and refugee women, aboriginal women, and African-Nova Scotian women, gender issues can be compounded by the effects of marginalization, racism or by cultural bias and systemic barriers within the heathcare sytem. There are also a number of specific social and health issues that affect women from these populations which also have implications for their health status.[9]

Recent research also indicates that income inequality—the unequal distribution of income in a society resulting in large income gaps between the rich and the poor—is also related to health status.[10] It is likely that gender inequality itself has an impact on women's health, since women's average income and their average employment earnings are both substantially smaller than men's. However, research on the overall impact of gender inequality on women's health is in its early stages and more work needs to be done on this issue and on the many other issues affecting women's health.[11]

One of the ways that women's economic inequality affects health is that women living on low incomes and those who work in low-paid jobs are less likely to carry supplementary insurance or have access to employer-related health plans. Since medicare does not cover many health-related services unless they are accessed through hospitals, low-income women without private health plans are likely to find it difficult to get the attention

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[7] R. Evans, M. Barer and T. Marmor (eds), *Why are Some People Healthy and Others Not? The Determinants of Health of Populations*. N.Y. Aldine de Gruyter, 1994.

[8] Ron Colman, GPI Atlantic, *Women's Health in Atlantic Canada: A Statistical Portrait*, *op.cit.*, p.22.

[9] See Lissa Donner, *Women, Income and Health in Manitoba: An Overview and Ideas for Action*, Women's Health Clinic, January 2002. Issues affecting immigrant and refugee women are well-documented in: Mary Ann Mulvihill, Louise Mailloux and Wendy Atkin, *Advancing Policy and Research Responses to Immigrant and Refugee Women's Health in Canada*, Centres of Excellence for Women's Health, 2001.

[10] CCSD, *Equality, Inclusion and the Health of Canadians: Submission to the Commission on the Future of Health Care in Canada*, November 15, 2001, pp.7-8.

[11] Six years ago, the government funded six research Centres of Excellence on Women's Health. Although funding for these centres has recently been renewed for another six years, the budgets for the centres have been cut.

they need when they need it or the same standard of care that middle- or upper-income Canadians enjoy, even though they are more likely to be in poor health.

Recent experience has taught women that because they carry the largest share of family responsibilities, they will be the ones who are expected to carry most of the caregiving burden arising from the effect of cutbacks, and the shortcomings and failures of the healthcare system. In some circumstances, this itself becomes a source of ill health for women.

With creeping privatization, the threat of user fees, and higher drug costs, it is not surprising that many women feel vulnerable. In the context of what many fear is a weak commitment to public health care at the political level, they are also concerned about the prospect of further cuts to healthcare and restructuring of the healthcare system.

We advocate below for the integration of population health and preventative approaches to health policy and a seamless, holistic approach to healthcare delivery. We also make the point that while there is room for change in the organization and delivery of health care, primary care needs to be strengthened and new publicly funded programs need to be added to the system. We believe that, in the long run, such changes will pay off in terms of the both the health and economic wellbeing of Canadians. However, these transitions will take time to achieve. They cannot be built in a climate in which a lack of funding for basic healthcare is putting people's health—and sometimes their lives— at risk.

II Values: Dignity, Equity and Social Inclusion

We are pleased that, in considering the future of the Canada's healthcare system, the Commission has asked Canadians to address values—whether they are articulated or not, values form the basis for decisions of all kinds, including public policy.

Our brief is based on the premise that most Canadians value equity (including gender equity), social inclusion, and respect for the dignity of the individual. We hope that these, or similar values, might also inform the deliberations of the Commission, and become the basis for both the long-term direction of healthcare policy and for healthcare policy decisions in the shorter term.

Recommendation:

1 Make a commitment to the values of dignity, equity (including gender equity), and social inclusion, in the provision of and access to healthcare, promoting the view that public expenditure on healthcare is an investment in the future wellbeing of Canadian society as a whole.

III Funding, Accessibility and the Canada Health Act

Espousing the values of dignity, equity, and social inclusion implies that the Commission and other decision-makers should focus on what is good for Canadian society as a whole, that you should look at the longer term social and economic benefits of expenditures on healthcare, and that you take into account the potential impacts policy decisions are likely to have on those who are most vulnerable in society. It also means that while decision-makers and Canadians as a whole cannot ignore the importance of maintaining a financially sustainable healthcare system, we also need to ensure that the values of equity of access, the dignity of the individual, and the inclusion of all—especially those at risk of social exclusion—are maintained and strengthened.

The current public debate about the fiscal sustainability of the healthcare system, however, is in danger of obscuring the present realities of those in need of care and, in particular, the long-term implications of declining federal contributions to healthcare.

The decline of federal funding has been an especially difficult problem for the provinces. According to a presentation to the Commission by Nova Scotia Minister of Health, Jamie Muir, Nova Scotia received less money in 2001/2002 from the CHST than in 1993/1994.[12] Even though Nova Scotia now spends almost 40% of its budget on healthcare, there have been hospital closures and a decline in access to primary care and other services, especially in rural areas, since the early 1990s. It is our belief that the decline in federal support for healthcare over the past 10 to 15 years has put at risk the fiscal sustainability of the healthcare system in Nova Scotia and that this is a primary reason why equitable access to medical treatment may be in jeopardy.[13]

This situation has also helped to nurture claims by some that we can no longer afford medicare unless we introduce user fees and/or privatize services. It has also created a climate in which people increasingly fear that, without the development of a two-tier system in the future, access to healthcare will be in jeopardy. Yet, as several reports have noted, compared with other OECD countries healthcare expenditures in Canada are not excessive. According to OECD data, Canadian public sector spending on health care is

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[12] The Honorable Jamie Muir, Minister of Health for Nova Scotia, *Presentation to the Commission on the Future of Health Care in Canada,* Wednesday April 17, 2002.

[13] Canadian Institute for Health Information data shows that total expenditures on health in Canada have risen since 1997 by $20 billion, but according to the CCSD these increases follow a period of cuts of around 2% a year between 1992 and 1997. They conclude that "In constant dollar, per capita terms, the actual and projected increases in public funding for the 1997 to 2001 period are offsetting the significant cuts earlier in the decade." Canadian Council on Social Development, *Equality Inclusion the Health of Canadians*, November 15, 2001, p.11.

below average.[14] We believe, therefore, that there is plenty of room for improving confidence in publicly funded healthcare through increased federal funding.

We therefore reject the introduction of user fees as a solution to financial sustainability. User fees have already been shown to be ineffective and will inevitably lead to inequity of access and put the dignity of the individual at risk. In the context of a population health approach, this so-called "solution" is also unlikely to result in savings in the long term as people avoid or delay treatment. Furthermore, we also do not believe that increased privatization of healthcare is a fair or equitable means of achieving fiscal sustainability for the healthcare system.

Canada already has one of the highest levels of privately-funded health service, at roughly 30% of total spending.[15] Indeed, as a result of funding restraints and other pressure on the system, private sector funding is now growing at an average annual rate of 2.5%, compared to average increases of 1.0% in the public sector. We have, therefore, already gone some way down the road to privatized services in Canada, and further privatization will inevitably lead to the institutionalization of two-tier or even three-tier systems of care. The Commission and other health care decision-makers must be wary of catering even more to private vested interests who are less likely to be concerned about the long-term effectiveness of the healthcare system or wellbeing of the population than the prospect of profiting from the current situation.

Moreover, there is little evidence that a parallel private system would be a solution to our current accessibility and quality of care problems. There is evidence, for example, that for-profit health care delivery is less accessible, more expensive, less efficient, less accountable, and often of poorer quality than publicly funded health care.[16] There are also grounds to fear that increased privatization of services will result in less, rather than more, support for publicly funded medicare and that overall, privatization will cost Canadians significantly more than supporting healthcare through taxes. Based on evidence from the United States, which has a very high degree of privatized healthcare services, privatization does not improve access to healthcare or the health of the population and it does not reduce costs as a share of national income. We must remember that whether it is through premiums to private insurers or through taxes for a public system, it is in the end the public who pays for healthcare. As the CCSD study previously cited has noted, "costs will be shifted from the public to the private sphere, from taxes to household budgets."[17]

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[14] Canadian public health sector spending accounted for 69.6% of total health care expenditures in 1998, compared to an average of 73.6% for all OECD Countries. By comparison, Canada has one of the highest levels of privately-funded health services, at roughly 30%. See CCSD, *Equality, Inclusion and the Health of Canadians, op.cit.*, p.11.

[15] Cited by CCSD in *Equality, Inclusion and the Health of Canadians, op.cit.*, p.11

[16] See evidence presented in CCSD, *Equality, Inclusion and the Health of Canadians, op.cit.* p.12 and Pat Armstrong *et al, Exposing Privatization: Women and Health Care Reform in Canada*, Garamond Press, 2002, p.27.

[17] CCSD, *Equality, Inclusion and the Health of Canadians, op cit*, p.11

The maintenance of the five principles of the *Canada Health Act*—portability, public administration, universality, accessibility and comprehensiveness—is the only way to ensure that the values of equity, social inclusion and individual dignity will have any chance of being maintained. In order to maintain legitimacy to enforce the *Canada Health Act*, however, the federal government must make a stronger commitment to the financing of health care. We suggest, therefore, that the *Canada Health Act* be strengthened with a formal commitment on the part of the federal government to share at least 25% of the costs of health care delivery with the provincial and territorial governments. We also suggest below that the *Canada Health Act* be broadened to include many of the areas essential to good health care which are not currently covered. This may entail "opening up" the Act to future negotiations with the provinces.[18]

If the Act is to mean anything substantively, there must also be a fair federal/provincial dispute-resolution process which is transparent and includes mechanisms for accountability to the Canadian public. We are pleased to note from recent media reports that a dispute-resolution process is now being seriously considered. In addition, however, we also need more effective means and mechanisms for accountability to the public for effectiveness in healthcare spending and for health outcomes.

Health outcomes generally take a population health approach and focus on measurable population health outcomes. These measures, however, tell us little about the kind of day-to-day concerns of patients which have prompted considerable public concern and media attention. As Colleen Flood and Tracey Epps point out in a seminal article on a Patient's Rights, these concerns largely relate to both the process of care and access to care. People need to be assured that there is both equitable access to care and that the quality of healthcare delivery is maintained.

This is why we believe there is merit in the idea of a Patient's Bill of Rights as advocated by the Institute for Research on Public Policy's Task Force on Health Policy and outlined in the paper by Flood and Epps.[19] A Patient's Bill of Rights would recognize both rights *in* health care and rights *to* health care, the former focusing on the patient/provider relationship and actual delivery of healthcare services, and the latter on access and quality of healthcare. Similar instruments have been introduced in other countries and should be seriously considered in the Canadian context.

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[18] See Monique Bégin, *Revisiting the Canada Health Act (1984): What Are the Impediments to Change?* 30th Anniversary Conference, Institute for Research on Public Policy, February 20, 2002.

[19] See Colleen Flood and Tracey Epps, *Can a Patient's Bill of Rights Address Concerns About Waiting Lists?* [Draft Working Paper] Health Law Group, Faculty of Law, University of Toronto, 9 October, 2001.

Recommendations:

2 Maintain, broaden and strengthen the *Canada Health Act*, with a commitment by the federal government to share at least 25% of the costs of healthcare delivery.

3 Develop a process of cost-sharing which is transparent and accountable to the Canadian public, and which includes a mutually agreeable federal/provincial dispute-resolution process.

4 Develop mechanisms to report to the Canadian public on the effectiveness of healthcare spending and on health outcomes.

5 Work with provincial and territorial governments to develop a pan-Canadian Patient's Charter of Rights.

6 Make a firm commitment by both levels of government to a publicly funded and non-profit health care system, with a clear rejection of two-tier healthcare, user fees, and the placement of limits on the expansion of privatized healthcare services.

IV The Scope of Public Healthcare Coverage

In Canada there is the common belief that we have a universal healthcare system protected under the *Canada Health Act*. This is, however, not the case. At a time when most health care services were delivered by physicians or through hospitals, Medicare was initially designed to cover only hospital treatments and doctors' fees. Coverage for prescription drugs, optical services, prosthetics and home care services were recommended in the Hall Royal Commission Report in the 1960s but, despite the principle of "Comprehensiveness" under the *Canada Health Act*, these services are still not fully covered.

In addition, the Act explicitly excludes long-term care in nursing homes, residential care services, and institutions for the mentally ill.[20] Many other treatments and examination procedures which are now recognized as essential to the maintenance of good health or to treat disease—such as dental care, eye care, prescription drugs and home care—may be partially covered, depending on the provincial jurisdiction, but they have never been universally covered under the federal Medicare plan. Moreover, due to pressures on costs, an increasing number of health care procedures and examinations that were previously fully covered under Medicare have been de-listed by provincial authorities and some new procedures are not routinely covered. The lack of public investment in new procedures, technologies and research has also meant that some treatments available in the U.S. are not available in Canada. Others are available in one province but not available in another.

This creates serious regional inequities in the provision and costs of care. For example, in some provinces the health and care components of long-term care costs are publicly funded. In Nova Scotia, as in the other Atlantic provinces, as long as an individual has assets to contribute and unless they can demonstrate "need", those admitted to long-term care are responsible for all of the costs, including residential and medical/care costs. Need is treated in a similar way as social assistance. Before a client is considered eligible for financial assistance for long-term care, all of their assets (other than the principal residence) are considered and must be liquidated to pay for their care. This costs about $50,000 a year. This situation places a burden on individuals and families and is certainly not conducive to maintaining individual dignity. Yet, in a province where the provincial government already pays almost 40% of all healthcare costs, which has an aging population, and a higher than average poverty rate, the Nova Scotia government legitimately argues that it simply cannot afford to pick up the full costs of care.

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[20] Canadian Health Coalition, *Standing Together for Medicare: A Call to Care, Submission to the Romanow Commission on the Future of Health Care in Canada*, November, 2001, p.11. A number of other authors and healthcare advocates have identified these limitations of coverage under Medicare and the *Canada Health Act*. These limitations have also been identified as barriers to the development of a more preventative approach and as a major impetus towards privatization of services. Most advocates of public health care caution, therefore, that because "primary care" is critical, reform should proceed only the basis of a strong commitment to publicly funded healthcare.

The lack of comprehensive coverage and the gaps and regional disparities in publicly funded healthcare coverage are not conducive to maintaining population health. In the long term they can, in fact, create higher healthcare costs and losses for the Canadian economy. Furthermore, they lead to further depletion of support for and public confidence in the Canadian healthcare system—helping to maintain and encourage the development of private health insurance. But this is only available to those who have access to good employer/employee health plans or to those who can afford the high premiums for private insurance. These problems also lead to social exclusion rather than to social inclusion—surely an issue of increasing concern to governments.

Given women's particular relationship to caregiving, their higher risk of poverty, the aging of the population, and the increasing numbers of both women and men who are employed in non-standard work with few employer-related benefits, we believe that most Canadians would welcome more comprehensive publicly funded healthcare coverage.

New pan-Canadian programs need to be developed to cover pharmacare, home care, and respite care. Provision of these services should be developed within the context of the provisions of the *Canada Health Act*. Pan-Canadian standards and more public resources must also be devoted to areas not currently fully covered by Medicare—such as long-term care, mental health services, dental care, eye care, disability aids, supports and the full range of therapies and rehabilitation services associated with disabilities.

Pharmaceuticals are increasing in cost and already many are beyond the reach of consumers who are not covered by insurance plans. The lack of a universal pharmacare plan is particularly problematic for elderly women, for low-income single mothers, and for the mentally ill, many of whom do not have access to private drug plans. As discussed above, women's life expectancy is longer than men's, but as they age women can expect to spend more years with a chronic illness or disability, and consequently they must rely to a greater extent on prescription drugs to ensure quality of life. Expensive prescription drugs can take a heavy financial toll on the many individuals and families without access to employment-related health plans or to the limited pharmacare plans which exist now. Individuals and families who care for adults or children with disabilities or chronic health conditions are particularly affected. Health issues and the fear of losing access to pharmacare, for example, have been identified as major barriers for single mothers who want to make a transition from social assistance to the labour market.

While we recommend a national pharmacare program—already envisioned by the National Forum on Health—we also urge the federal government to improve and maintain measures to avoid the over-prescribing of prescription drugs. We advocate against the loosening of laws and regulations that prevent inappropriate marketing of pharmaceuticals. Of particular concern is an increase in direct-to-consumer advertising of prescription drugs, which heightens demand without sufficient regard for safety and efficacy.

Mental health is another area which is not only misunderstood by the public at large, but also neglected within the health care system. Certain kinds of mental health conditions (e.g., depression) affect women more than men and there is a need for better access to a variety of treatments and a broader range of services than exist at present for such

conditions. Further, the high cost of many psycho-pharmaceuticals forces a continuing dependence on public assistance, where pharmacare is provided. Employment, on the other hand, often does not provide enough income to allow purchase of hundreds of dollars' worth of drugs each month.

Over-treatment with medications has in the past been identified as a problem, especially as far as women's health is concerned, so we do not advocate for a greater use of prescription drugs where these are not necessary. Nevertheless, many people with long-term mental health conditions do need medications on a regular basis and in some cases under-treatment rather than over-treatment can be a problem. People with mental health conditions in Nova Scotia, for example, frequently do not have access to private drug plans through the workplace and Nova Scotia Pharmacare is limited to the elderly and people on social assistance. The treatment of mental health issues, therefore, could also be enhanced by the addition of a universally available pharmacare program.

As our population ages, a new home care program and better provision for long-term care will be essential to the maintenance of health and quality of life for the elderly and for their caregivers. Access to home care services is particularly pressing for older Canadians who, in the context of cuts to hospital funding and early release policies, are increasingly cared for at home. It is also important to their family members, especially women, who are increasingly called upon to provide medical care at home for elderly relatives, often with little ongoing support.[21] A related issue is the need for a formal respite care program for those who care on an ongoing basis for the chronically ill or for people with disabilities. In recent years, for example, we have seen the tragic results of inadequate support and respite care for those who care for persons with severe disabilities.

Dental care, eye care and speech/language/hearing care are also essential to the maintenance of good health and they should be considered vital components of a real universal healthcare system. In recent years, however, dental and eye care examinations and most treatments, including those for children over the age of 10, have been de-listed in Nova Scotia. Although people with private work-related health care plans may have access to dental and eye care, many people who work in low-wage jobs, who are outside of the formal labour market, or who have retired, do not.

Expanding the scope of medicare will obviously be more costly in the short term, but increased expenditures need to be viewed as an investment in social inclusion and in the future health of the population, rather than simply as a cost to the public purse. In summary, expanding the scope of public healthcare coverage—putting more emphasis on prevention, environmental health, health promotion and on changing the mode of healthcare delivery—is likely to save Canadians money in the long term.

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[21] Maritime Centre of Excellence for Women's Health, *Home Care and Policy: Bringing Gender Into Focus, Gender and Health Policy Discussion Series Paper No. 1*, March 1998.

Recommendations:

7 Work with the provinces to develop a plan for a more comprehensive system of public healthcare which includes fully developed home care, long-term care, pharmacare and respite care programs.

8 Strengthen and enforce laws and regulations to prevent inappropriate marketing of pharmaceuticals, such as direct-to-consumer advertising of prescription drugs.

9 Institute pan-Canadian eligibility requirements for admission to licensed care facilities, whereby residents pay for room and board only, with the upper limit of cost based on OAS/GIS.

10 Ensure adequate funding for supports and services not currently fully covered by Medicare or other federal transfers, such as disability aids and supports, the provision of remedial and rehabilitation services, and mental health services.

11 Ensure that eye care, speech/language/hearing therapies, and dental care examinations are covered under Medicare so that examinations and treatment are available to those without work-related health plans.

V The Organization of Primary Care

Women have long advocated for a more holistic approach to the delivery of primary care than presently exists. Delivery of primary care at the moment in Canada, however, does not appear to be very efficient, is often inconvenient for patients, and in many instances may not be conducive to good health outcomes.

The system of primary care should be under-pinned (though of course not replaced) with increased emphasis on prevention and population health (*see below*). At the same time, our primary care system should increase its capacity to provide care for the whole person by developing ways to take a more "seamless" approach to delivery and access. There is, however, evidence that the fee-for-service method of compensating physicians is not cost-effective and that it may prevent the development of this kind of approach. The method of paying physicians, therefore, should be re-examined. [22]

Although the issue of the pros and cons of fee-for-service for physicians and different modes of funding providers were not discussed in any depth by the National Forum on Health, the final report in 1997 noted that "there is, however, broad recognition of the need to make the necessary changes to put patients, rather than providers, at the centre of the system." [23] We believe that the fee-for-service system may discourage the development of continuity of care services, such as community health centres or clinics, which in our view would be better and more effective models for primary healthcare delivery.

In the interests of better access, efficiency and convenience, as well as a more holistic approach to health care, therefore, we believe that the development of community health centres or clinics should be encouraged. Such centres may include in one location physicians, nurse practitioners, and various non-medical healthcare professionals (such as physiotherapists, social workers and mental health professionals). There are a few models in Canada of how this approach could work effectively, but lessons in *best practices* could also be drawn from other countries with experience in alternative forms of delivery, such as the U.K. or Scandinavia.

Many women would also like to see changes and a more holistic approach to women's sexual and reproductive health using a community clinic approach to delivery. Well Woman Clinics, for example, are now well-accepted by women but access is uneven because their frequency and whether they happen at all depends to a large degree on volunteers or voluntary community agencies. A system of publicly funded clinics to include

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[22] A number of health researchers and advocates have drawn attention to this issue. For one cogent argument see Luc Theriault, Carmen Gill and Michael McCubbin, *Allied Services and the Health of Canadians: Acting Outside the Hospital-Centred Box*, a brief submitted to the Commission on the Future of Health Care in Canada, December 14, 2001.

[23] Striking a Balance Working Group, National Forum on Health, *Canada Health Action: Building on the Legacy, Synthesis Reports and Issues Papers, Vol. II*, 1997, p. 32.

preventative measures could very well be developed to focus more specifically on women's reproductive and sexual health. An increased use of midwifery for maternal and maternity care should also be encouraged when thinking about new models for healthcare delivery both inside and outside of hospitals.

Recommendations:

12 Re-examine the fee-for-service method of paying physicians for their services in the context of the need for a more holistic and seamless system of delivering primary care.

13 Encourage the primary care system to provide a more holistic, seamless approach through the development of adequately-staffed community health centres or clinics with flexible hours and a range of healthcare services, making better use of nurses and nurse practitioners and including physiotherapists, midwives and various non-medical healthcare professionals within a system which emphasizes continuity of care.

14 Provide better funding for Well Woman Clinics and develop publicly funded clinics which provide specialized services related to women's sexual and reproductive health.

VI Towards Prevention and a Population Health Approach

Espousing the values of equity, social inclusion and dignity means that our thinking about the future of healthcare policy in Canada must go beyond simply preserving the "healthcare system" as we currently define it. Whether it is in relation to health promotion, how we understand and treat illness, or the organization of healthcare services, women's organizations have long advocated for more holistic approaches than presently exist. Women, therefore, have also been at the forefront of championing a population health model because this places as much emphasis on addressing the economic, social and cultural determinants of health as on the treatment of illness.

A population health approach links health and wellbeing not only to biology and genetic endowment, but to such social and economic determinants as income, gender, culture, education, the social and physical environment, and the availability of services, support networks and facilities which are "outside" the healthcare system as currently defined.[24] As noted above, for example, there is growing evidence of a link between poverty and poor health status, as well as between health status and the level of income disparity in the population.[25] Women's health status is, therefore, likely affected by gender inequality evident in the prevailing income disparities between women and men and by particularly higher levels of low income for some groups of women, such as single mothers, women with disabilities, elderly unattached women, and women from racially-marginalized groups.[26]

We are pleased, therefore, that governments at both levels now say they are committed to a population health approach and to more preventative initiatives in healthcare. There is, however, one *caveat* to our endorsement of these approaches. The population health approach is evidence-based and because it focuses on the health issues of populations and prevention, there is the fear that if the new approach is used simply as a rationale for restructuring and shifting resources from the treatment of illness to prevention, it could have repercussions on access to and the quality of healthcare. It is high time that population health and preventative approaches in health policy development move from the production of documents explaining the concepts, to practical measures to implement them.[27] However, Canadians need to be reassured that access to healthcare services and

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[24] For a plain language explanation of the population health approach and the determinants of health, see *Taking Action on Population Health: A Position Paper for Health Promotion and Programs Branch Staff*, Health Canada, Population Health, 1998.

[25] Dennis Raphael, "From Poverty to Societal Disintegration: How Economic Inequality Affects the Health of All Canadians," *Toronto Star*, 27 January 1999.

[26] Lissa Donner, *Women, Income and Health in Manitoba: An Overview and Ideas for Action*, Women's Health Clinic, January 2002.

[27] See CCSD, *Equality, Inclusion and the Health of Canadians: Submission to the Commission on the Future of Health Care in Canada*, November, 14, 2001, p.10 and pp. 16-18.

the quality of care will not be jeopardized and this is another argument for the development of something akin to a Patient's Bill of Rights (*see discussion of this above*).

A population health approach has implications for the kind of commitments governments at both levels should make, not only to policies affecting healthcare directly, but in the wide array of social, environmental and economic policies which affect the wellbeing and quality of life of Canadians.[28] The population health approach also has specific implications for how we understand women's health, for action in a range of policy areas affecting women's health, and for the design of programs directed to women.[29]

With the absence until relatively recently of gender-based research, researchers are only now beginning to understand how women's social and economic status and other factors related to gender are, on their own, determinants of women's health and at the same time interact with and compound the impacts of other determinants such as genetic endowment and culture.[30] To become effective, therefore, a population health approach must not only be informed by research but by the kind of research which is more inclusive of women and women's health concerns, as well as of the cultural and racial diversity in Canadian society.

Moving towards population health and preventive approaches in healthcare will likely entail making some changes in the organization and delivery of healthcare as we know it. But if these are to be taken seriously, they must go beyond simply a rationale for restructuring the healthcare system in order to save money. The change in focus which is implied by a population health approach must entail action in the full range of policy areas affecting population health—addressing their negative impacts, as well as promoting positive outcomes. It is ironic, for example, that while the largest portion of federal transfers to the provinces under the Canada Health and Social Transfer (CHST) is devoted to healthcare delivery, social programs which address the social determinants of health, and which could support more favourable population health outcomes, are being cut back, are in jeopardy, or cannot be developed for lack of money. This makes little sense from a population health perspective.

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[28] For a fuller discussion of the determinants of health and a population health approach, see *Determinants of Health Working Group Synthesis Report in Canada Health Action: Building on the Legacy, Vol. II*, National Forum on Health, 1997.

[29] See "An Overview of Women's Health" in *Canada Health Action: Building on the Legacy, Vol. II*, National Forum on Health, 1997.

[30] The need for more research of this kind in Canada has been demonstrated by various symposia and a body of research produced by the six Centres of Excellence for Women's Health funded in part by Health Canada. If measured against the health issues that existing research has identified, however, the centres are seriously under-funded in terms of the addressing the research gaps. For research on health issues affecting women in Nova Scotia, see Atlantic Centre of Excellence for Women's Health website: *www.medicine.dal.ca/mcewh*

This situation, however, could be improved if the federal government took its own commitment to population health seriously by ensuring that in addition to the restoration of a fair contribution to healthcare funding, the federal government also ensured that the provinces receive adequate financial resources to address social programs and social services. Given the strong institutional pressures on healthcare expenditures currently (and for the foreseeable future), we believe that this could best be achieved through three separate transfers—for healthcare, for social programs and for education.[31]

Recommendations:

15 Recognize and promote a population health approach to achieve better overall health outcomes, stressing the need for governments to take into account the full range of the social and economic the determinants of health, including gender and culture, in all government policies and practices.

16 Allocate more resources to environmental health, prevention, and health promotion within the system, ensuring that policies and programs are sensitive to gender and cultural diversity and include rural communities.

17 Replace the CHST with a separate transfer of funds for healthcare and for social programs and education.

18 Promote and support gender and cultural diversity research to lead to better understanding of the determinants of women's health and recognition of the specificity of women's health care needs within the delivery system, and in health care education and training.

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[31] A similar argument has been made by the Hon. Monique Bégin, who as Minister of Health in the late 1970s and early 1980s helped to create the *Canada Health Act*. See *Revisiting the Canada Health Act (1984): What Are the Impediments to Change?* Institute for Research on Public Policy, 30th Anniversary Conference, February 20, 2002. See also Canadian Health Coalition, *Standing Together for Medicare: A Call to Care, A Submission to the Romanow Commission on the Future of Health Care in Canada*, November, 2001, p.23.

VII Conclusion

As the Commission is undoubtedly aware, there is a great deal of uncertainty about what the future holds for healthcare in Canada. People are aware that the realities of fiscal constraints in recent years have placed a great deal of pressure on the delivery of healthcare. Many fear that as we move towards greater integration with the United States, this will also mean that we will be in danger of abandoning the ideals and values that underpin healthcare in Canada—that we will move increasingly towards a user-pay system in which individuals bear the costs and where some get access to adequate care while others do not. We have noted a variety of reasons why women in particular have a great deal of concern about the issues relating the future of healthcare and why we have a particular interest in maintaining a strong publicly funded healthcare system.

We have argued that the provision of healthcare must be viewed from a population health perspective and that user fees, increased privatization of services, the de-listing of treatments and the under-development of others, are not conducive to population health. Public funding for healthcare should be viewed as a long-term investment which will pay off not only in terms of health outcomes, but in terms of its benefits for the economy as well.

In this regard, we have made the case that while changes can and should be made in the organization and delivery of primary care to improve efficiency and effectiveness of delivery, there is room for broadening the scope of medicare through the development of new programs and for strengthening others. We have also noted that there are legitimate fiscal concerns at the provincial level about the costs of healthcare delivery, but that this situation could be significantly improved with a clearer commitment to specific levels of funding on the part of the federal government.

We have also made several recommendations about strengthening and broadening the *Canada Health Act* to ensure that our healthcare system improves rather than deteriorates. It is our hope that the Commission will act on our recommendations so that the Canadian healthcare system not only maintains the values on which it was built, but that the values of dignity, equity and social inclusion will also guide its future.

APPENDIX: Recommendations

1. Make a commitment to the values of dignity, equity (including gender equity), and social inclusion, in the provision of and access to healthcare, promoting the view that public expenditure on healthcare is an investment in the future wellbeing of Canadian society as a whole.

2. Maintain, broaden and strengthen the *Canada Health Act*, with a commitment by the federal government to share at least 25% of the costs of healthcare delivery.

3. Develop a process of cost-sharing which is transparent and accountable to the Canadian public, and which includes a mutually agreeable federal/provincial dispute-resolution process.

4. Develop mechanisms to report to the Canadian public on the effectiveness of healthcare spending and on health outcomes.

5. Work with provincial and territorial governments to develop a pan-Canadian Patient's Charter of Rights.

6. Make a firm commitment by both levels of government to a publicly funded and non-profit health care system, with a clear rejection of two-tier healthcare, of user fees, and the placement of limits on the expansion of privatized healthcare services.

7. Work with the provinces to develop a plan for a more comprehensive system of public healthcare which includes fully developed home care, long-term care, pharmacare and respite care programs.

8. Strengthen and enforce laws and regulations to prevent inappropriate marketing of pharmaceuticals, such as direct-to-consumer advertising of prescription drugs.

9. Institute pan-Canadian eligibility requirements for admission to licensed care facilities, whereby residents pay for room and board only, with the upper limit of cost based on OAS/GIS.

10. Ensure adequate funding for supports and services not currently fully covered by Medicare or other federal transfers, such as disability aids and supports, the provision of remedial and rehabilitation services, and mental health services.

APPENDIX: Recommendations *(cont'd)*

11 Ensure that eye care, speech/language/hearing therapies, and dental care examinations are covered under Medicare so that examinations and treatment are available to those without work-related health plans.

12 Re-examine the fee-for-service method of paying physicians for their services in the context of the need for a more holistic and seamless system of delivering primary care.

13 Encourage the primary care system to provide a more holistic, seamless approach through the development of adequately-staffed community health centres or clinics with flexible hours and a range of healthcare services, making better use of nurses and nurse practitioners and including physiotherapists, midwives and various non-medical healthcare professionals within a system which emphasizes continuity of care.

14 Provide better funding for Well Woman Clinics and develop publicly funded clinics which provide specialized services related to women's sexual and reproductive health.

15 Recognize and promote a population health approach to achieve better overall health outcomes, stressing the need for governments to take into account the full range of the social and economic determinants of health, including gender and culture, in all government policies and practices.

16 Allocate more resources to environmental health, prevention, and health promotion within the system, ensuring that policies and programs are sensitive to gender and cultural diversity and include rural communities.

17 Replace the CHST with a separate transfer of funds for healthcare and for social programs and education.

18 Promote and support gender and cultural diversity research to lead to better understanding of the determinants of women's health and recognition of the specificity of women's health care needs within the delivery system, and in health care education and training.

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